SPECIAL ARTICLE

REPORT ON THE FORMATION OF THE CANADIAN PSYCHIATRIC ASSOCIATION

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THE CANADIAN PSYCHIATRIC ASSOCIATION came into existence June 20, 1951, at its inaugural meeting held in Salon C of the Mount Royal Hotel in Montreal. This is therefore an historic date for the future records and archives of this first autonomous national association of Canadian psychiatrists.

Although this paper should be limited to the title assigned to it by the program committee, nevertheless it seems appropriate to review not only the steps leading to the formation of the Canadian Psychiatric Association, but also to mention briefly other organizations with which Canadian psychiatrists have been particularly identified since the beginning of psychiatric history in Canada.

No attempt will be made in this paper to discuss the development of psychiatric institutions in Canada as this subject was thoroughly covered in the 4 volume work published in 1918 entitled "Care of the Insane in the United States and Canada". However, the development of psychiatry as a specialty in Canada during the last 35 years could well form the subject of another paper and might be concerned with the improvement of psychiatric treatment procedures in our mental hospitals, the gradual emancipation of psychiatry from neurology, the development of the mental hygiene movement, the teaching of psychiatry in our medical schools at both the undergraduate and graduate levels, the introduction of psychiatry into the general hospitals and into private practice, the certification of specialists in psychiatry and the contribution of psychiatry in the two world wars.

The first organization in which Canadian psychiatrists held membership was the Association of Medical Superintendents of American Institutions for the Insane, which was the name by which the American Psychiatric Association was originally known. It was formed by thirteen American asylum administrators in Philadelphia in 1844. At its first meeting it agreed to admit Canadian asylum superintendents on equal terms and Dr. Walter Telfer, superintendent of the Lunatic Asylum at Toronto (as it was then called), attended the second meeting which was held in Washington, D.C. in 1846. Canadian psychiatrists have held membership continuously since that date. In 1892 its name was changed to the American Medico-psychological Association and in 1921 it became the American Psychiatric Association. In 1892, membership which formerly had been restricted to superintendents of mental institutions, was opened to all physicians specializing in mental disorders. Although Canadians constitute only a small percentage of its membership, they have always been treated with the greatest generosity by their American colleagues. Six Canadians have been honoured with the presidency of the American Psychiatric Association, many have served on its council and committees and several of the annual meetings have been held in Canadian cities. Formation of the Canadian Psychiatric Association will not deprive Canadians of membership in the American body, which in the future, as in the past, will continue to be the great meeting place for the psychiatric sciences and the exchange of psychiatric knowledge.

Although there has not previously been an autonomous body of Canadian psychiatrists, a section of psychiatry was established in the Canadian Medical Association in 1945. The first meeting of the section was held in 1946 and yearly meetings have been held since that date for the presentation of scientific papers. It should be noted, too, that as far back as 1929 a section of Mental Diseases was set up by the Canadian Medical Association with Dr. C. A. Porteous as chairman and Dr. E. C. Menzies as secretary, holding its first meeting in Montreal. The section held a meeting the following year in Winnipeg, in a conjoint meeting between the Canadian Medical Association and the British Medical Association. It appears that no further meetings were held until the present section on psychiatry was inaugurated in 1945.

One other national body deserves mention in this connection. The National Committee for Mental Hygiene (Canada) was established in 1918 by the late Dr. C. K. Clarke and Dr. C. M. Hincks. Dr. Clarke was probably the first Canadian psychiatrist to devote himself to preventive psychiatry. This body, which changed its name in 1950 to the Canadian Mental Health Association, has had relatively few psychiatrists actively participating in its work, but a great many Canadian psychiatrists have had liaison relationships with it of a very valuable sort, and its efforts have been outstanding for the improvement of mental hospitals, for the establishment of mental health clinics, for better mental health in all citizens through education, and for the encouragement of research in mental health and mental disease.

There are also several other psychiatric organizations of more circumscribed geographical areas. The Ontario Neuropsychiatric Association was founded in 1920, holding its first meeting at the Ontario Hospital, Kingston, with Dr. E. J. Ryan as president. It has no formal membership lists, and is sponsored by the Hospitals division of the Ontario Department of Health, chiefly for the education of the physicians in its own mental hospital service, but also for the benefit of other psychiatrists, neur-

ologists and physicians in other types of practice. Meetings are held in various parts of the province several times a year and papers delivered at its meetings are usually published in the Association's bulletin.

Psychiatrists in the Province of British Columbia join with their colleagues in the states of Oregon and Washington in the North Pacific Society of Neurology and Psychiatry, an affiliate society of the American Psychiatric Association. An annual meeting is held. Vancouver psychiatrists are also members in a section of neuropsychiatry of the Vancouver Medical Association, which section was established in 1945.

Although Saskatchewan does not have a definite psychiatric society, it has an approximation to it in what is called a Provincial Psychiatric Clinical Conference. This is a multi-professional organization, formed in 1949, for the improvement of mental health standards and facilities in various fields.

There is a psychiatric section of the Manitoba division of the Canadian Medical Association which was organized in 1947. Meetings are held four times a year. Likewise, in the Ontario Medical Association, a section on neurology and psychiatry was organized as recently as May 24, 1951, during the Ontario Medical Association meeting in Toronto.

It should also be noted that the Montreal Medico-chirurgical Society has had a Section of Psychiatry since 1933 (formed officially March 3, 1933). The Toronto Academy of Medicine likewise has had a section of Neurology and Psychiatry since 1933, the first meeting being held in January of that year.

Until comparatively recent decades the practice of psychiatry was confined to the mental hospitals. Even as recently as twenty-five years ago the only psychiatry in private practice was performed by neurologists, and the mental hygiene movement was barely started. Since then there has been a remarkable expansion of psychiatric fields of interest, such as the development of mental health clinics, the establishment of psychiatric services in general hospitals (still all too few), the extension of psychiatric services in the armed forces for the selection of recruits and the treatment of psychiatric disorders, the increase of personnel in the departments of psychiatry in our medical schools, the inclusion of the neuroses and psychosomatic disorders in the field of psychiatry which has oriented most practitioners to the psychic element in disease and is taking an increasing number of psychiatrists into the private practice of psychiatry as a specialty. The expansion of our mental hospitals due to population increase has called for ever increasing numbers of psychiatrists in such institutions, a field which is of increasing attractiveness because of the many advances in therapeutic techniques. It is estimated there are now some 500 or more psychiatrists and psychiatrists-in-training in Canada.

After World War II it was thought by some of us that a section on psychiatry in the Canadian Medical Association would satisfy the interests of psychiatrists across Canada in these various fields and would enable us to have closer relationships with our colleagues in general medicine and the other specialties. This section held its first meeting in 1946 and has served a very valuable purpose for scientific intercourse.

However, it soon became apparent that there were other features of importance to psychiatrists which could not be served conveniently by such a section, as the sections have no direct authority or power to negotiate except through the Council of the Canadian Medical Association. And although Council has been most gracious and co-operative, nevertheless it could not be expected to have the time to represent Canadian psychiatrists adequately in such problems as the place of psychiatrists in the armed services, relationships with universities, the Royal College of Physicians and Surgeons and the Dominion and Provincial governments, as well as in the development of psychiatric clinics and services in general hospitals and in various other matters, such as medico-legal.

Informal discussions began in 1948 which led to the calling of a meeting of all Canadian psychiatrists in Montreal during the meeting of the American Psychiatric Association in May, 1949. At this meeting an interim committee was set up to ascertain the opinion of Canadian psychiatrists as to the need of an autonomous body and to proceed with plans of organization if opinion was favourable. All Canadian psychiatrists whose names and addresses were available were asked if they would be interested in joining such an autonomous body. The response was almost entirely favourable to such a step being taken.

The interim committee called meetings of Canadian psychiatrists who would be attending the American Psychiatric Association in Detroit in May, 1950 and the Canadian Medical Association in Halifax in June, 1950.

At these two meetings the interim committee was instructed to apply to Ottawa for the incorporation of a body of psychiatrists to be known as the Canadian Psychiatric Association. In this matter the interim committee was ably assisted by Dr. K. G. Gray, who offered to prepare the necessary application forms, and with the help of Dr. John Griffin, to prepare a draft constitution and by-laws to accompany the application. Letters patent, incorporating the Canadian Psychiatric Association, have been issued within the last month.

Application forms for membership have been distributed in recent months to all Canadian psychiatrists. All applications received were dealt with by the interim committee at a meeting held in Montreal on the morning of June 20 and all those approved by the interim committee were accepted as the charter members of

the Canadian Psychiatric Association.

At the inaugural meeting of the Canadian Psychiatric Association held on June 20, as already indicated, the following officers were elected: President: R. O. Jones, Halifax; Vice-president, C. G. Stogdill, Ottawa; Secretary, J. P. S. Cathcart, Ottawa; Treasurer: R. C. Hamilton, Ste. Anne de Bellevue. The newly elected officers and councillors assumed their respective offices. The Canadian Psychiatric Association has been born and has been launched into the stream of Canadian medical life. May it have a long and useful career.

CLINICAL AND LABORATORY NOTES

EXPERIENCE WITH PLASTIC INSERTS FOR MIDDLE EAR DEAFNESS*

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THE USE of various types of artificial drums is as old as otology itself. Most of us have had the experience of improving the hearing in individuals whose drums have been largely destroyed, by small pledgets of cotton sprayed with oil and carefully positioned in the middle ear. Various prostheses have been devised for the same purpose, such as the Leonard ear drum, but they have never been used much by otologists because they were made of rubber and had a tendency to irritate the mucosa of the middle ear and set up a discharge and were difficult to keep in a sterile condition.

Recently Pohlman of California has been advocating the use of small plastic tubes made in different sizes and shapes to be used in this type of patient. Having had some experience with these recently both personally and with a number of patients, I thought it might be worthwhile to present these observations for your consideration.

There are two main types of patients who are suitable; first, those who have had a partial or total destruction of their drum from previous otitis media; secondly, those with radical mastoid cavities. In the case of perforations, the opening must be fairly large, at least 4 mm. in diameter, and must involve the posterior half of the middle ear so that the oval and round windows are exposed to direct view. They must, of course, have a good functioning inner ear as indicated by good bone conduction, and both the stapes and round window must be freely movable. This latter condition is ascertained by the use of an acoustic probe. This is merely a fine bamboo stick tipped with a rounded bead of hard wax, attached to a rectangular piece of thin cardboard. The free end of the sterilized bamboo stick is gently applied to the medial wall of the middle ear, in the region of the oval or round window, while the examiner talks quietly close to the cardboard baffle. If there is a sensitive area the patient immediately notices a marked increase in loudness of the examiner's voice, and an insert is worth a trial. If this test is negative there is no use in proceeding further.

In deciding what size to use, generally with perforations, sizes 1 or 2 are most suitable, while with radical cavities the larger sizes are necessary, *i.e.*, 4 or 5. They do not maintain their position quite as well with radical cavities as they do when there is a rim of drum present. They are most helpful if the ear is dry, but can be worn successfully in the presence of chronic discharge if it is not profuse.

The particular cone shape required in any case depends on the angle of the canal or radical cavity to the sensitive area. I have found D and E most useful. I have tried using inserts with little angulated projecting tails, for cases where the sensitive area was hidden behind or above a rim of drum, but have not found them of any practical value because they are too difficult to get into the right position.

The inserts are not of much practical help in losses greater than 45 db; such people should wear a hearing aid. They are most helpful in losses between 30 and 45 db. At this level they are missing enough to be a constant source of worry and nerve strain, but the loss is not sufficient for them to be willing to accept an electric hearing aid.

The inserts are removed every evening, washed in soap and water, dipped in aqueous zepherin, (1 in 1,000) and put in a small sterile bottle until morning. Most patients can learn very readily how to put them in, in a few seconds, by listening to a running tap or a radio, with the other ear closed.

In suitable cases the improvement is very readily measured on the audiometer by checking the 512 threshold before and after insertion, as most gain is usually obtained at this frequency. There is always a definite improvement of 15 or 20 decibels when the insert is in proper position. Actually, the number of hard-of-hearing people who are of a suitable type to benefit from these inserts is very limited, but to those few they offer very worthwhile and practical help. Learning how to choose the right size and shape in some cases requires practice and patience, but once achieved the pleasure and gratitude of the patient is ample reward for the effort.

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